Guam Behavioral Health and Wellness Center		
TITLE: Entries in the Medical Record	REFERENCE #: MR-17	PAGE: 1
DIVISION: Inpatient/Outpatient- Medical Records	CMS: 482.24(c)(1)	
APPROVED BY: _____ REY M. VEGA, DIRECTOR	EFFECTIVE: 8/11/2013	
	REVISED:	

POLICY:

A. All entries in the medical record shall be legible, complete, dated, timed, and authenticated, in written or electronic form, by the person (identified by name and discipline) responsible for providing or evaluating the service provided.
   a. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented.

B. GBHWC shall ensure that entries in the medical record are only made by authorized individuals.

C. Staff must be trained and competent in the fundamental documentation practices of this facility and legal documentation standards.

D. All entries in the medical record must be legible to all individuals.

E. All entries must be typed or handwritten using only black or blue ink.
   a. Allergies may be written in all capital letters.

F. All entries in the medical record are permanent.

G. All abbreviations listed in the GBHWC Unacceptable Abbreviation and Symbol List (F-MR-10) is prohibited for use in medical record documentation.

H. Entries in the medical record shall be documented and filed in the chart as soon as possible after the event (i.e., change in clinical state, unit round, etc.) and before the relevant staff member goes off duty.
   a. Refer to the Late Entries in the Medical Record Policy and Procedure (MR-13) for further guidance.

I. Pre-dating or back-dating an entry in the medical record is prohibited.

J. All medical records must be maintained in their entirety and no document or entry may be deleted/removed from the record.

K. All papers and forms in the chart must be secured.
   a. Sticky notes containing clinical information, counseling, and test results are subject to HIPAA Privacy Rules and should be transcribed into the medical record and destroyed after completion.

L. The medical record should contain original documents whenever possible.
   a. Documents received from another health care facility do not need to be in original form.

M. All photo-copied documents shall be completely legible.

N. Original entries must not be obliterated and any inaccurate information should still be readable.
   a. Refer to the Correction to Entries in the Medical Record Policy and Procedure (MR-07).

DEFINITIONS:

1. **Authentication:** Identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.
   a. The aim is to prevent unauthorized people from using another person's identity to sign documents.

   b. Entries may be authenticated by an electronic signature, signature stamp, or computer key in accordance with the Stamp Signatures and Initials for Identification Policy and Procedure (MR-26).

2. **Signature:** Identifies the author or responsible person who takes ownership of and attests to the information contained in the entry.

PROCEDURE:

A. All documentation and entries in the medical record, both paper and electronic, must be identified with the consumer's full name (last, first, middle initial), date of birth, and unique GBHWC medical record number.

B. Each page of a double-sided or multi-page form must be marked with the consumer's first and last name, date of birth, and medical record number, since single pages may be photocopied, faxed and separated from the whole record.

C. There shall be no crowding or writing in the margins.

D. If there is unused space within a document (i.e., progress note) a line must be drawn from the end of the entry to the end of unused space.

E. Any blank spaces on forms must be "X'ed" out or the word "Deferred" must be written in the areas left blank.
   a. Every required space shall be filled on forms or flow sheets.
      i. "Not applicable" or "N/A" should be noted rather than leaving the space blank.

F. There shall be no documentation on the back of a one-sided form.

G. Individuals authorized to document in the medical record are as follows:
   a. Community Program Aids
   b. Dietitians
   c. Family partners
   d. Interns
   e. Nurses
   f. Pharmacists
   g. Physicians/Psychiatrists
   h. Psychiatric social workers
   i. Psychiatric Technicians
   j. Psychologists
   k. Social workers/ Care coordinators
   l. Students (i.e., MD, RN, occupational therapy)
   m. Therapists
   n. Youth coordinators
   o. Designees from the following divisions:
      i. Healing Hearts
      ii. Drug and Alcohol
      iii. Child and Adolescent Services
   p. Any other individual providing care for the consumer who has a need to communicate consumers' progress.

H. A co-signature is only needed if the staff making an entry is being supervised by a clinician who is ensuring they are properly delivering the service (i.e., MD co-signing for a resident, staff co-signing for interns, etc.)
   a. The person who is making the countersignature must be qualified to countersign.
      i. For example, a licensed nurse who doesn't have the authority to supervise should not be countersigning an entry for a student nurse who is not yet licensed.

I. Individuals authorized to document physician's orders in the medical record are as follows:
   a. Physicians

   b. Registered Nurses accepting telephone or verbal orders

J. The medical record may include documents that are transmitted by facsimile machine; provided that the faxed copies are on non-thermal paper and that the faxed copies are dated and authenticated.
   a. GBHWC accepts a faxed signature.

K. When dating an entry, the date must be documented as MM/DD/YYYY.

L. When documenting the time, it shall be written in military time format.
   a. For example, if the document was signed at 2:30 PM, the time would read "1430".

   b. Charting time as a block (i.e. 7-3) especially for narrative notes is not advised.
      i. Narrative documentation should reflect the actual time the entry was made.

      ii. For certain types of flow sheets such as a daily nursing flow sheet, recording time as a block could be acceptable.

REFERENCES:

1. GBHWC Unacceptable Abbreviation and Symbol List (F-MR-10)
2. Late Entries in the Medical Record Policy and Procedure (MR-13)
3. Correction to Entries in the Medical Record Policy and Procedure (MR-07)
4. Stamp Signatures and Initials for Identification Policy and Procedure (MR-26)